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Patient History Form

New Client: 6 Years and Older

Please complete and return this form at least 7 days before your child's first scheduled appointment, along with the following, if applicable: physician's referral, previous evaluation reports from other educational, audiological, psychological or speech professionals. If you have one available, it is helpful to include a current picture of your child.

1. Contact/Insurance Information

Child's Legal First Name: _____
Nickname:_____
Child's Last Name: _____
Date of Birth: _____ Age: _____
Gender/Pronouns: _____

Address:_____
City/Zip:_____
Home Phone:_____

Mother's/Guardian's/Partner's Name:_____
Occupation:_____Employer:_____
Email: _____ Cell:_____

Father's/Guardian's/Partner's Name:_____
Occupation:_____ Employer:_____
Email: _____ Cell:_____

How did you hear about our practice? _____

Do you intend to seek insurance reimbursement? ❑Yes ❑No

If you checked "yes," please read a copy of our information sheet, "If You Intend to Seek Insurance Reimbursement". We would like to send your physician a copy of any reports pertaining to your child's care. Please sign below to give us permission to do so.

Name/Address of Child's Primary Physician who will be referring for services:
_____
Name of Insurance Company_____
Policy Holder_____ Policy Number_____

I give permission for Hamaguchi & Associates to provide information to my insurance company and referring physician as requested for the purpose of reimbursement:

Parent Signature_____ Date_____

2. Family Information

Parent(s) Status:

- ❑ Solo/single parent
- ❑ Legally married
- ❑ Living together
- ❑ Domestic partnership
- ❑ Living apart (If so, who is the primary legal custodian?)_____

Name and age of child's siblings_____
Does anyone else live with you? _____
Do you have any pets? Please tell us about them.
_____

3. Child's Birth/Developmental History

❑ Biological child ❑ Adopted ❑ Presently a foster child

For adopted/foster children:
If adopted or foster child, at what age the did the child join family? _____
If available, please describe the care/history of your child prior to joining your family (e.g. in orphanage from birth, taken from natural parents at age 3, in 5 foster homes since 18 months, etc.) Pre-placement information: _____
_____
_____

At the time the child was placed with you, were there developmental delays or health/behavioral issues? Please explain:_____
_____

Pregnancy and Birth
Any complications or time spent in the NICU?
_____
_____

Weight at birth (if known)? _____

Developmental Milestones

When did your child walk independently?_____
When do you recall the first real word was spoken? _____
At what age did you first become concerned about your child's speech-language development and why?
_____

4. Health History

Is your child presently taking any prescription medication?

❑ Yes ❑ No

If yes, please tell what it is and why it is taken _____

In the past, has your child taken medications to treat AD/HD (such as Ritalin, Concerta, or Stratera)?

❑ Yes ❑ No

If yes, for how long/when/was it successful? _____

In the past, has your child taken medications to treat neurobiological conditions such as obsessive compulsive disorder, anxiety or depression?

❑ Yes ❑ No
If yes, for how long/when/was it successful? _____

Does your child take any vitamins, supplements, or non-prescription medication?
❑ Yes ❑ No
If yes, please tell what it is and why it is taken _____ _____

Any major illnesses or surgery to date?
❑ Yes ❑ No
If yes, please explain _____

Any history of seizures?
❑ Yes ❑ No
If yes, explain what happened and at what age:_____

History of ear infections?
❑ Yes ❑ No
If yes, how frequent? Ventilation tubes? _____

Known vision problems? _____

Allergies? _____

Do you have concerns about your child having anxiety or depression? _____

Sleep:
What time does your child typically go to sleep? _____
What time does your child typically wake up? _____

Describe the sleeping patterns: (check all that apply)
- ❑ Sleeps in his/her own room
- ❑ Sleeps in the bed with us
- ❑ Sleeps on our floor
- ❑ Gets up at night: please describe how often and why (scared, can't sleep, misses you) _____

Does your child snore?
❑ Yes ❑ No

If yes, has your child been evaluated by a sleep specialist for sleep apnea?
❑ Yes ❑ No

Does your child seem sleepy during the day at times you wouldn't expect?
❑ Yes ❑ No

5. Language History

Language(s) spoken in the home_____
If English is the only language that has been spoken to your child, please skip down to #3 below.

For children learning more than one language:

What languages has your child been raised to speak by his/her primary caregiver(s)? _____
At what age was your child introduced to English on a regular basis? _____

What settings is your child currently spoken to in English(in percentages)?
home _____ % school _____%
What language do you feel is your child's strongest language? _____

Do you find that your child is weak/behind in both languages? ❑Yes ❑No

**Please note that if your child's strongest language is a language other than English or is fairly equal (bilingual) we will need to do a bilingual assessment if there are any issues or concerns, other than simple pronunciation difficulties. By comparing language and listening skills in both languages, we can better determine if the difficulty is pervasive (a true disorder) or simply a weakness in learning English. This is important for us to know in developing a treatment plan, but also for assigning the appropriate diagnostic codes. Currently, we are only able to offer bilingual assessments in Mandarin/English. Due to the amount of time it takes to administer, score and transcribe the additional testing, these assessments are higher in fees. Please discuss this with our office staff or Director of Clinical Services at the initial intake session.

6. Which speech/language/auditory areas below are of a concern to you about your child?

- ❑ Pronunciation- If yes, what sounds is your child struggling with? _____
- ❑ Doesn't say many/any real words yet
- ❑ Talks very little—you have to pull everything out to get more than a phrase or quick sentence
- ❑ Mouth muscles seem weak or uncoordinated
- ❑ Chewing/swallowing
- ❑ Sentence structure-words are mixed up
- ❑ Grammar is poor ("I rided my bike")
- ❑ Vocabulary is weak
- ❑ Doesn't look at people when they are talking to him/her
- ❑ Has a hard time answering the question you are asking
- ❑ Needs things repeated before it "sinks in"
- ❑ Gets confused with oral directions
- ❑ Mixes up the names of familiar places and people—seems to have word retrieval issues
- ❑ Reading comprehension is below average
- ❑ Writing/spelling skills are below average
- ❑ Has a hard time paying attention, staying focused
- ❑ Has difficulty with phonemic awareness (e.g. telling the first sound in a word, blending sounds)
- ❑ Says "like" or "uh" or "um" too often
- ❑ Teachers express concerns about your child's communication or listening skills
- ❑ Misinterprets idioms, slang and takes them very literally
- ❑ Repeats what he/she hears out of context—speech is very scripted
- ❑ Talks too fast
- ❑ Talks too loud
- ❑ Talks too quietly
- ❑ Talks slower than expected
- ❑ Speech is mumbly and indistinct
- ❑ When talking, rambles and talks TOO much, especially about his/her favorite topic
- ❑ Has a hard time having social conversations
- ❑ Tends to dominate conversations
- ❑ Says very little in conversations
- ❑ Says things that are socially inappropriate at times (e.g. tells someone they don't like their new haircut)

7. Social interaction and behavior (check all that apply)

- ❑ Typical for age
- ❑ Quiet
- ❑ Outgoing
- ❑ Tends to prefer playing alone
- ❑ Gets in trouble at school (Explain:_____)
- ❑ Wants to play with others, but has trouble making or keeping friends
- ❑ Says odd things (Example_____)
- ❑ Makes odd noises
- ❑ Prefers to play with younger children
- ❑ Tends to say/do socially inappropriate things for a child his age
- ❑ Is unusually active for his/her age
- ❑ Has a shorter attention span than you expect for his/her age

- ❑ Avoids eye contact
- ❑ Is disinterested in other children
- ❑ Unusually irritable or uncomfortable in noisy or crowded places such as malls, parties
- ❑ Has many fears (e.g. won't sleep alone, won't go into a public restroom alone, bugs)
- ❑ Is bullied
- ❑ Can be a bit rigid and inflexible
- ❑ Is talkative at home, but fairly quiet/shy in school
- ❑ Has social anxiety
- ❑ Likes to touch, tap or grab things he/she shouldn't, even after being told to stop
- ❑ Will ask you the same question over and over
- ❑ Will often do the exact opposite of what authority figures (parents/teachers) want them to do
- ❑ Doesn't respond to his/her name consistently
- ❑ Doesn't respond to his/her name if engaged in TV/video games (hyperfocused)
- ❑ Can be unusually argumentative
- ❑ Dislikes long sleeves, tags in shirts
- ❑ Sometimes will (please circle) bite, hit, scratch, kick other adults or children if unhappy
- ❑ Tattles on others more than expected
- ❑ Has a hard time if there is a change in routine or unexpected change in plans
- ❑ Likes to play with others, but doesn't seem to know how
- ❑ Gets annoyed at friends/peers if they don't do what he/she wants them to do
- ❑ Will talk to others, but stands too close or too far away, or doesn't get their attention first
- ❑ Watches others play but stands back a bit
- ❑ Tries to join an ongoing activity or group but doesn't do so appropriately

Does your child have any strong interests (e.g. trains, maps, dinosaurs, hand-washing, Pokemon), **repetitive movements, tics** (e.g. blinking, sniffing, head movements, etc.) **or behaviors** (e.g. licking hands, chewing on shirt, etc)**?**

- ❑ Yes Please list or describe:

  _____
- ❑ No

Sometimes will:

- ❑ Bite
- ❑ Hit
- ❑ Scratch
- ❑ Kick other adults or children if unhappy

If yes, under what conditions (where/when/with whom) do you see these behaviors?

_____

Any other issues regarding behavior or social skills?

_____

_____

8. About Your Child

Is there a history in the family of speech, language or learning disabilities of any kind, including hyperactivity or Attention Deficit Disorder?

❑ Yes ❑ No

If yes, please explain_____

Has your child previously been diagnosed with a particular condition that would affect his or her speech, language or auditory skills? (such as Down Syndrome, Autism, PDD, Cerebral Palsy, Hearing Impairment, etc.)

❑ Yes ❑ No

If yes, please explain _____

Is your child aware of his/her condition/difficulties or diagnosis? ____ yes ____ no

If yes, how does your child feel about coming for therapy? What has been told regarding the reason for coming to our office? _____

_____

Do you want help from the speech-language pathologist for you to talk to your child about his/her condition? If so, please elaborate how we can help you.

_____

_____

What are your child's favorite activities and games? _____

What upsets your child?_____

Tell us about your child's personality._____

_____

Please summarize your primary reason for bringing your child to us for an evaluation or therapy (i.e. specific concerns and goals) We also ask that you include a separate letter telling us about your child if you have not already done so. If coming for an assessment, is there a condition or disorder you are looking to rule in or rule out? _____

_____

_____

Does your child read?

❑ Yes ❑ No

If yes, how would you describe his/her decoding skills (figuring out the words)?

❑ Below age/grade level ❑ Above age/grade level
❑ At age/grade level ❑ Not sure

If your child reads, how would you describe his/her comprehension of what is read?

❑ Below age/grade level ❑ Above age/grade level
❑ At age/grade level ❑ Not sure

Sometimes we use videos or apps during our therapy sessions for a very limited time. Are you comfortable having your child use screens/electronic devices during therapy?

_____

9. Previous Evaluations and Therapy

Has your child been evaluated or treated for a speech problem in the past?

❑ *Yes ❑ No

If yes, when and by whom?_____

Please send us any previous reports.

Is your child currently receiving speech therapy at another practice, with another agency, or school?

❑ Yes ❑ No

If yes, please explain why you are seeking to change or add a new speech pathologist to your child's program?_____

Has your child been evaluated or treated by a physical or occupational therapist?

❑ Yes ❑ No

If yes, when and by whom?_____

Diagnosis: _____

Is your child still currently receiving occupational therapy?

❑ Yes ❑ No

Where?

❑ Through school ❑ Through a private practice _____

How often does your child receive OT and what is he/she working on? (e.g. sensory regulation, fine-motor, etc.)

_____

Has your child been evaluated by a psychologist, educational therapist, or learning consultant?

❑ Yes ❑ No

If yes, when and by whom?_____

Diagnosis/Recommendations:_____

Has your child been evaluated by a neurologist?

❑ Yes ❑ No

If yes, when and by whom?_____

Diagnosis/Recommendations:_____

Has your child had a thorough hearing evaluation?

❑ Yes ❑ No

If yes, when and by whom? _____

Diagnosis/Recommendations: _____

Has your child been evaluated by a BCBA (behavioral specialist)?

❑ Yes (Please fill in date and by whom below) ❑ No

Date:_____ By Whom:_____

Is your child currently receiving ABA services? And if so who is the ABA provider? How many hours (locaton—home/school?) _____

_____

If your child is receiving ABA therapy, how is your child responding to therapy? Has it been helpful? What kinds of activities are being done during ABA? Do you have any concerns regarding your child's program?

_____

_____

_____

10. Oral-Motor/Diet & Nutrition

Do you have any concerns about your child's chewing/eating skills?

_____

Do you feel your child is a picky eater, such as eating only cold foods, yellow foods, soft/white foods, etc.?

_____

Is your child on a restricted diet?

❑ Yes ❑ No

❑ Previously, no longer

If yes, which kind?

❑ Gluten-free/casein-free ❑ Vegan

❑ Dairy free ❑ Diabetic/sugar-free

❑ Vegetarian ❑ Other (please indicate)_____

How long has your child been on a restricted diet? _____

What is the purpose of the restricted diet? (e.g. to improve focus/attention, due to allergies, cultural reasons, improve symptoms of autism)_____

If your child was previously on a restricted diet, please tell more about your child's experience. (What kind of diet, for how long, did you notice any changes, etc.) _____
_____

Has your child ever had his/her tongue tie clipped or has a dentist mentioned this (or a lip tie) to be a potential issue to monitor?
_____

Does your child suck his/her thumb?

- ❑ never did
- ❑ yes, still does
- ❑ used to, but has stopped

If so, about what age did your child stop? _____

11. Educational/ Interventions History

Tell us about your child's current educational program:

- ❑ public-school (Name/city:_____)
- ❑ private school (Name/city:_____)
- ❑ home-schooled (Name/city: _____)

- ❑ Regular classroom (Grade:_____)
- ❑ Special education classroom
- ❑ A combination of regular classroom mainstreaming and special ed

Please describe the current classroom setting: _____

Is your child receiving any special services through the public school IEP? Please check all that apply:

- ❑ speech therapy
- ❑ occupational therapy
- ❑ resource teacher help in the classroom
- ❑ teacher aide in the classroom that assists your child
- ❑ adapted P.E.
- ❑ ABA Therapy
- ❑ assistive listening device
- ❑ augmentative communication device
- ❑ other:_____

What are your child's favorite school subjects? (if any) _____

What are your child's least favorite school subjects? _____

What services has your child received privately?

- ❑ Lindamood-Bell programs When? _____ Was it helpful? _____
- ❑ Tomatis Listening Therapy When? _____ Was it helpful? _____
- ❑ Biofeedback When? _____ Was it helpful? _____
- ❑ Tutoring When? _____ Was it helpful? _____
- ❑ Social/Pragmatic Group When? _____ Was it helpful? _____
- ❑ Fast ForWord When? _____ Was it helpful? _____
- ❑ Interactive Metronome When? _____ Was it helpful? _____
- ❑ Auditory Integration Training (AIT) When? _____ Was it helpful? _____
- ❑ Cognitive-Behavioral Therapy (CBT) When? _____ Was it helpful? _____
- ❑ Counseling When? _____ Was it helpful? _____
- ❑ Reading Tutoring When? _____ Was it helpful? _____
- ❑ Educational Therapy When? _____ Was it helpful? _____
- ❑ Naturopathy/homeopathy remedies When?_____ Was it helpful? _____ Which supplements did you use? _____

- ❑ Other: _____

Please tell about your child's school experiences (areas of strength, areas of difficulty, what's working, what's not)

_____

_____

_____

Please fill out an "Exchange of Information" form for us to communicate with other professionals regarding your child's assessment or therapy program, if you so desire.

By signing below, I am indicating that
1) I have the legal right to make all decisions regarding my child's speech and language therapy program.
2) I am not withholding health or educational information that is known to me.
3) I accept financial responsibility for all services requested and provided at Hamaguchi & Associates.

Parent's Name (print please) _____

Parent's Signature _____Date_____

We look forward to getting to know your child and working with you!